charge does not escape freely—the retained portion becoming decomposed—the making of a counter-opening at the lowest part of the cavity, and introducing a tube, is shown by the first of Dr. Goodfellow's cases, and the one recorded by Dr. Gordon, to be highly advantageous.

5. In cases of hydro-pneumothorax, such as Dr. Goodfellow's second case, and Dr. M'Dowell's, the introduction of the tube may not only palliate the sufferings of the patient, but prolong life.

6. The removal of the tube must not be attempted so long as pus continues to be secreted; but when this has ceased the tube may be withdrawn as shown by Dr. Banks' case, Dr. Gordon's, and by that of Mrs. J. A. M., now recorded. When the tube seems to be keeping up the discharge, we may, by inserting silk threads, keep the opening patulous, so as to allow fluids to escape; and, at the same time, retain in our hands the means of reintroducing the tube with facility if the necessity for it should occur. The number of threads need not be great, and may be gradually reduced. The boy Hill had but a single thread in the opening for many months.

The introduction of the tube is a very simple operation. An opening is made with a scalpel at the usual place for tapping, between the fifth and sixth ribs, about midway between the spine and sternum. An instrument is now to be passed in, and the cavity explored; it is then made to press against the intercostal space at the lowest part of the cavity, and is easily detected by the finger placed opposite to it, when it is cut down upon with a scalpel. * * * In my case I used a uterine sound. The broad handle of this instrument, and its firmness, enabled me to explore the cavity satisfactorily, and to make sufficient pressure on the intercostal space to guide the knife in cutting down on it. Having passed it through I secured a ligature on it, which the bulbous form of its point held securely while I withdrew the instrument. I then attached the tube to the ligature, and easily drew it through the opening. In the case I saw Dr. M'Dowell operate on recently, he used the same instrument. The curved trocar of Chassaignac might be used in the operation, but it appears to me to be very inferior to the uterine sound. After its introduction it is necessary to withdraw the trocar, leaving the canula in the wound, and reintroduce it with the blunt end foremost, to explore the cavity; then having fixed on the place for making the counter opening, the trocar must again be withdrawn and reversed; and, unless the instrument is very much better made than any I have seen, this cannot well be done without shifting the canula out of the position that had been decided on; and even if this difficulty be overcome, there is considerable danger of injuring the intercostal artery in perforating the wall of the thorax from within outwards, as it lies in an exposed situation on the inside of the rib.

The tubes sold in the shops are of two kinds, vulcanized rubber and pure rubber. The vulcanized has no advantages, as the temperature of the body is quite enough to keep the pure rubber elastic at all times; and if the tube has to be worn for any length of time the vulcanized rubber may become brittle, as it usually does when long in use. The tube ought to be shifted occasionally, lest the openings should be closed. In my case, I placed the ends of the tube in a small waterproof sponge-bag, slung round the shoulders, and fastened close to the openings by a slip of adhesive plaster, which, being attached to the skin at one edge, and to the inside of the bag at the other, served also to direct the current into the bag.

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44. *Pyæmia.*—The *Medical Times and Gazette* of January 7, 1865, contains a tabulated report of ten cases of pyæmia which occurred in King's College Hospital during the year 1864, and the number of the same journal for Jan. 21 contains one of thirteen cases which occurred during the same period in St. George's Hospital, all twenty-three cases terminating fatally.

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45. *Diagnosis between Syphilitic and Non-Syphilitic Diseases of the Skin.*—An abstract of a paper on this subject, by Mr. B. SQUIRE, was read before the Harveian Society of London (Nov. 3, 1864). The author, after remarking on the importance of the subject observed that an eruption, even when the question

of antecedent primary syphilis was well made out, was by no means necessarily of syphilitic origin; and that where an eruption was clearly syphilitic, it was often extremely difficult to obtain a history of primary syphilis. He, therefore, placed very little reliance on inquiries of this kind as a means of diagnosis. The best evidence that we could obtain of the nature of an eruption was the evidence that was within our personal knowledge. The most reliable direct evidence of previous chancre was the cicatrix left by that chancre. One of the most important means of distinction between syphilitic and non-syphilitic eruptions was the situation of the eruption. The most frequent situations for syphilitic eruptions, in the order of their frequency, were the neighbourhood of the alæ of the nose, the angles of the mouth, the forehead near the roots of the hairs, the back of the neck near the roots of the hairs, the inner canthus of the eyelids, the middle of the chest, the inner surfaces of the limbs, the neighbourhood of the axillæ and groins. It might be stated generally that the face was the most favourite locality for syphilitic eruptions. The age at which syphilides most commonly appear for the first time was another means of diagnosis. The most common age for this was between 25 and 35. Infantile syphilis appeared generally at the age of one month. The earliest time at which the author had met with a syphilitic eruption dependent on syphilis communicated by intercourse was in the case of a female aged 8 years. The colour of the eruption was a favourite, but, unless under certain restrictions, a fallacious means of diagnosis. He meant that the notion that a coppery tint would enable one to distinguish syphilitic from non-syphilitic eruptions was an erroneous one; this tint was found more or less marked in every case of non-syphilitic psoriasis. Again, syphilitic eruptions did not present it at all at their outset; it was only as they became developed that the coppery tint gradually appeared. The form of the eruption was a more reliable means of diagnosis. Most commonly this was annular or oval. If not in actual rings, the eruption formed segments of circles—incomplete rings; or by the juxtaposition of two rings, it might form figures of eight. This, of course, however, would not enable us to distinguish, as by a touchstone, syphilitic from non-syphilitic eruptions. Psoriasis, *e. g.*, sometimes occurred in rings; so did lichen; so, again, did herpes circinatus. Lupus was another example of a non-syphilitic eruption of annular form. The absence of itching and smarting was a peculiarity which would often aid in the recognition of a syphilide. The mixed character of syphilitic eruptions was another means of distinguishing them. Thus, in an eruption that was not syphilitic, it was rare to find rashes mixed with vesicles, or pustules with scales. Not so in a syphilide. What might be termed the "products of the eruption" —such as the scales or the crusts—were a means of diagnosis. The scales of a syphilitic eruption were finer, smaller, and more adherent to the surface beneath than those of a simple squamous disease. The scaly patch, too, was circumscribed by a whitish border, to which great importance had been attached by Biett as a diagnostic symptom. This whitish border was the result of the separation of the epidermis from the cutis around the diseased patch. The crusts, which might either follow the scales or succeed to pustules, were much harder, thicker, and greener than the crusts of a simple cutaneous disease; they were sometimes, at all events at their centre, as thick as they were broad. The ulcers that were left by either pustular or tubercular syphilides were generally circular, with abrupt and perpendicular edges, and a gray pultaceous floor, the skin around them having a copper tint. The scars left by a syphilide, though at first of a violet hue, soon acquired even a more tawny-brown tint than the eruption that had preceded them; this tint in its turn at length faded, but even when the scar had at length been left perfectly white, its annular or reticulated form, as the case might be, would distinguish its origin. Another means of recognizing a syphilitic eruption was attention to other changes produced by syphilis besides those wrought in the skin itself. With regard to the sore-throat, we should be on our guard against relying too much on it as a diagnostic symptom. There were many diseases of the skin (and some that resembled pretty closely one or other of the syphilides) that were dependent on scrofula, or, at all events, occurred more frequently in the scrofulous than in any other constitution. No people were more liable to sore-throats than the scrofulous, and perhaps no two diseases were more frequently confounded together than syphilitic lupus and the lupus that occurs in the scrofulous. In doubtful cases the question "Have you suffered from sore-throat?" is often allowed to settle the difficulty. The most characteristic condition of a syphilitic sore-throat was either the presence of mucous tubercles or of cicatrices. The presence of mucous tubercles, either in the throat or elsewhere, was one of the most conclusive signs of syphilis that one could have. The erythema of the buttocks and scrotum, that was so common in sickly children whose cleanliness was hardly attended to, was often mistaken for infantile syphilis, and if they happened to have a cold at the same time, it was still more likely to be set down to a specific cause. This mistake happened the more commonly that simple erythema in infants, as it faded, often assumed more or less of a tawny tint. The effect of the common remedy for infantile syphilis—gray powder—on the other class of cases, was greatly to aggravate them. Again, the author had frequently seen severe cases of eczema in infants taken for infantile syphilis, and treated for it with the same unfavourable result. There was no better or surer means for establishing the disease to be syphilitic than the existence of mucous tubercles when these were present, and in the majority of cases of infantile syphilis they were. Their most common situations were, the angles of the mouth, the alæ of the nose, the vulva, the anus, the scrotum, or within the mouth. The author then referred to rheumatic pains in the limbs, along the bones, or in the larger joints, to bitemporal neuralgia, to falling off of the hair, to indolent swellings of the glands of the neck, and, in the female, frequent abortion, or stillbirths, or suspension of the catamenia (not arising from any other ascertainable cause), as evidences of the syphilitic nature of an eruption, and to the chronic course and the progressive changes in the character of the syphilides, observing, however, that it was not upon any one symptom alone, but on the general issue of the evidence afforded by many symptoms, that we should rely for our diagnosis of syphilides from the other diseases of the skin. He concluded by expressing his regret that the limits of a paper precluded his entering on the much larger subject of the diagnosis of the different syphilides from the several diseases of the skin for which they might be taken.—*Med. Times and Gaz.*, Jan. 28, 1865.

OPHTHALMOLOGY.

46. *Extraction of Soft Cataract by Suction.*—Mr. T. PRIDGIN TEALE, Jr., of Leeds, states (*Lancet*, Sept. 24, 1864) that the difficulty sometimes met with in certain cases of linear extraction of cataract in which the soft matter is removed either incompletely or only after repeated introduction of the curette, induced him to try whether suction might not be employed in withdrawing through a small incision in cornea cataracts which have neither a hard nucleus from old age nor have undergone calcareous degeneration. Having satisfied himself that the softer portions of even a healthy lens could be sucked through a fine tube, he had a suction instrument modelled upon the ordinary curette. His original instrument consisted simply of a tubular curette fixed in a handle, to which a small India-rubber tube[1] with a mouth-piece is attached. The flexible tube is of such a length as to reach from the mouth of the operator to the curette when held in the eye.

Shortly afterwards Messrs. Weiss made, at the suggestion of Mr. Bowman, a modification of this instrument, in which the suction power is applied by an ingenious mechanism in the handle, so that the hand which holds the curette controls the suction. Mr. Bowman also inserted a piece of glass tube between the curette and the handle, to enable the operator to watch the result of the

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[1] The idea of the flexible tube was probably suggested to me by reading an article by Mr. Greenway, of Plymouth, in which he describes a suction instrument for making artificial pupil.